

111TH CONGRESS  
1ST SESSION

# S. 1634

To amend titles XVIII and XIX of the Social Security Act to protect and improve the benefits provided to dual eligible individuals under the Medicare and Medicaid programs.

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## IN THE SENATE OF THE UNITED STATES

AUGUST 6, 2009

Mr. ROCKEFELLER (for himself, Mr. AKAKA, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend titles XVIII and XIX of the Social Security Act to protect and improve the benefits provided to dual eligible individuals under the Medicare and Medicaid programs.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

### 3   **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “Medicare Prescription Drug Coverage Improvement  
6       Act”.

7       (b) **TABLE OF CONTENTS.**—The table of contents of  
8       this Act is as follows:

Sec. 1. Short title; table of contents.

## TITLE I—MEDICARE AND MEDICAID IMPROVEMENTS

- Sec. 101. Providing Federal coverage and payment coordination for low-income Medicare beneficiaries.
- Sec. 102. Creating a Medicare operated prescription drug plan option.
- Sec. 103. Accreditation requirement for all specialized Medicare Advantage plans and revisions relating to specialized Medicare Advantage plans for special needs individuals.
- Sec. 104. Providing better care coordination for low-income beneficiaries in Medicare part D.
- Sec. 105. Improving transition of new dual eligible individuals to Medicare prescription drug coverage and presumptive eligibility for low-income subsidies.
- Sec. 106. Required information on transition from skilled nursing facilities and nursing facilities to part D plans.
- Sec. 107. Streamlined pharmacy compliance packaging.
- Sec. 108. Lowering covered part D drug prices on behalf of Medicare beneficiaries.
- Sec. 109. Correction of flaws in determination of phased-down State contribution for Federal assumption of prescription drug costs for dually eligible individuals.
- Sec. 110. No impact on eligibility for benefits under other programs.
- Sec. 111. Quality indicators for dual eligible individuals.

## TITLE II—ADDITIONAL MEDICARE AND MEDICAID IMPROVEMENTS

### Subtitle A—Improving the Financial Assistance Available to Low-Income Medicare Beneficiaries

- Sec. 201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
- Sec. 202. Eliminating barriers to enrollment.
- Sec. 203. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
- Sec. 204. Exemption of balance in any pension or retirement plan from resources for determination of eligibility for low-income subsidy.
- Sec. 205. Cost-sharing protections for low-income subsidy-eligible individuals.

### Subtitle B—Other Improvements

- Sec. 211. Enrollment improvements under Medicare parts C and D.
- Sec. 212. Medicare plan complaint system.
- Sec. 213. Uniform exceptions and appeals process.
- Sec. 214. Prohibition on conditioning Medicaid eligibility for individuals enrolled in certain creditable prescription drug coverage on enrollment in the Medicare part D drug program.
- Sec. 215. Office of the Inspector General annual report on part D formularies' inclusion of drugs commonly used by dual eligibles.
- Sec. 216. HHS ongoing study and annual reports on coverage for dual eligibles.
- Sec. 217. Authority to obtain information.

**TITLE I—MEDICARE AND  
MEDICAID IMPROVEMENTS**

**SEC. 101. PROVIDING FEDERAL COVERAGE AND PAYMENT**

**COORDINATION FOR LOW-INCOME MEDICARE  
BENEFICIARIES.**

(a) ESTABLISHMENT OF FEDERAL COORDINATED  
HEALTH CARE OFFICE.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Not later than October  
1, 2009, the Secretary of Health and Human  
Services (in this section referred to as the “Sec-  
retary”) shall establish a Federal Coordinated  
Health Care Office.

(B) ESTABLISHMENT AND REPORTING TO  
CMS ADMINISTRATOR.—The Federal Coordi-  
nated Health Care Office shall—

(i) be established within the Centers  
for Medicare & Medicaid Services; and

(ii) report directly to the Adminis-  
trator of the Centers for Medicare & Med-  
icaid Services.

(2) PURPOSE.—The purpose of the Federal Co-  
ordinated Health Care Office is to bring together of-  
ficials of the Medicare and Medicaid programs at the

1 Centers for Medicare & Medicaid Services in order  
2 to—

3 (A) more effectively integrate benefits  
4 under the Medicare program under title XVIII  
5 of the Social Security Act and the Medicaid  
6 program under title XIX of such Act; and

7 (B) improve the coordination between the  
8 Federal Government and States for individuals  
9 eligible for benefits under both such programs  
10 in order to ensure that such individuals get full  
11 access to the items and services to which they  
12 are entitled under titles XVIII and XIX of the  
13 Social Security Act.

14 (3) GOALS.—The goals of the Federal Coordi-  
15 nated Health Care Office are as follows:

16 (A) Providing dual eligible individuals full  
17 access to the benefits to which such individuals  
18 are entitled under the Medicare and Medicaid  
19 programs.

20 (B) Simplifying the processes for dual eli-  
21 gible individuals to access the items and serv-  
22 ices they are entitled to under the Medicare and  
23 Medicaid programs.

1 (C) Improving the quality of health care  
2 and long-term services for dual eligible individ-  
3 uals.

4 (D) Increasing beneficiary understanding  
5 of and satisfaction with coverage under the  
6 Medicare and Medicaid programs.

7 (E) Eliminating regulatory conflicts be-  
8 tween rules under the Medicare and Medicaid  
9 programs.

10 (F) Improving care continuity and ensur-  
11 ing safe and effective care transitions.

12 (G) Eliminating cost-shifting between the  
13 Medicare and Medicaid program and among re-  
14 lated health care providers.

15 (H) Improving the quality of performance  
16 of providers of services and suppliers under the  
17 Medicare and Medicaid programs.

18 (4) SPECIFIC RESPONSIBILITIES.—The specific  
19 responsibilities of the Federal Coordinated Health  
20 Care Office are as follows:

21 (A) Providing States, specialized MA plans  
22 for special needs individuals (as defined in sec-  
23 tion 1859(b)(6) of the Social Security Act (42  
24 U.S.C. 1395w–28(b)(6))), physicians and other  
25 relevant entities or individuals with the edu-

1 cation and tools necessary for developing pro-  
2 grams that align benefits under the Medicare  
3 and Medicaid programs for dual eligible individ-  
4 uals.

5 (B) Working with the Director of the Con-  
6 gressional Budget Office and the Director of  
7 the Office of Management and Budget, and in  
8 consultation with the Medicare Payment Advi-  
9 sory Commission and the Medicaid and CHIP  
10 Payment and Access Commission, to, not later  
11 than January 1, 2011, establish dynamic scor-  
12 ing for benefits for dual eligible individuals to  
13 account for total spending and savings for com-  
14 parable risk groups under the Medicare pro-  
15 gram.

16 (C) Supporting State efforts to coordinate  
17 and align acute care and long-term care serv-  
18 ices for dual eligible individuals with other  
19 items and services furnished under the Medi-  
20 care program.

21 (D) Providing support for coordination of  
22 contracting and oversight by States and the  
23 Centers for Medicare & Medicaid Services with  
24 respect to the integration of the Medicare and

1 Medicaid programs in a manner that is sup-  
 2 portive of the goals described in paragraph (3).

3 (5) REPORT.—The Secretary shall, as part of  
 4 the budget transmitted under section 1105(a) of  
 5 title 31, United States Code, submit to Congress an  
 6 annual report containing recommendations for legis-  
 7 lation that would improve care coordination and ben-  
 8 efits for dual eligible individuals.

9 (b) ADDITION OF MEDICAID REPRESENTATIVES TO  
 10 MEDICARE PAYMENT ADVISORY COMMISSION AND CON-  
 11 SULTATION WITH MEDICAID AND CHIP PAYMENT AND  
 12 ACCESS COMMISSION.—

13 (1) ADDITION OF MEDICAID REPRESENTATIVE  
 14 TO MEDICARE PAYMENT ADVISORY COMMISSION.—  
 15 Section 1805(c)(2)(B) of the Social Security Act (42  
 16 U.S.C. 1395b–6(c)(2)(B)) is amended by adding at  
 17 the end the following sentence: “Such membership  
 18 shall also include at least 2 individuals who are na-  
 19 tionally recognized for their expertise in financing,  
 20 benefits, and provider payment policies under the  
 21 program under title XIX.”.

22 (2) CONSULTATION WITH MEDICAID AND CHIP  
 23 PAYMENT AND ACCESS COMMISSION.—Section  
 24 1805(b) of the Social Security Act (42 U.S.C.

1       1395b–6(b)) is amended by adding at the end the  
 2       following new paragraph:

3               “(9) CONSULTATION WITH MEDICAID AND CHIP  
 4       PAYMENT AND ACCESS COMMISSION.—In carrying  
 5       out the duties of the Commission under this sub-  
 6       section, the Commission shall consult with the Med-  
 7       icaid and CHIP Payment and Access Commission  
 8       established under section 506 of the Children’s  
 9       Health Insurance Program Reauthorization Act of  
 10      2009 (Public Law 111–3) on an ongoing basis.”.

11      (c) MACPAC FUNDING AND TECHNICAL AMEND-  
 12      MENTS.—

13              (1) FUNDING.—Section 1900(f) of the Social  
 14      Security Act (42 U.S.C. 1396(f)) is amended—

15              (A) in the subsection heading, by striking  
 16              “AUTHORIZATION OF APPROPRIATIONS” and  
 17              inserting “FUNDING”;

18              (B) in paragraph (1), by inserting “(other  
 19              than for fiscal year 2009)” before “in the same  
 20              manner”; and

21              (C) by striking paragraph (2) and insert-  
 22              ing the following:

23              “(2) APPROPRIATION.—Out of any funds in the  
 24      Treasury not otherwise appropriated, there is appro-



1        priated to MACPAC \$11,403,000 for fiscal year  
 2        2009 to carry out the provisions of this section.

3            “(3) AUTHORIZATION.—In addition to amounts  
 4        made available under paragraph (2), there are au-  
 5        thorized to be appropriated for fiscal years begin-  
 6        ning with fiscal year 2010, such sums as may be  
 7        necessary to carry out the provisions of this section.

8            “(4) AVAILABILITY.—Amounts made available  
 9        under paragraphs (2) and (3) to carry out the provi-  
 10       sions of this section shall remain available until ex-  
 11       pended.”.

12           (2)        TECHNICAL        AMENDMENTS.—Section  
 13        1900(b) of such Act (42 U.S.C. 1396) is amended—

14                (A)    in paragraph (1)(D), by striking

15                “June 1” and inserting “June 15”; and

16                (B) by adding at the end the following:

17                “(10) CONSULTATION WITH MEDPAC.—

18                        “(A) IN GENERAL.—MACPAC shall regu-  
 19        larly consult with the Medicare Payment Advi-  
 20        sory Commission (in this paragraph referred to  
 21        as ‘MedPAC’) established under section 1805 in  
 22        carrying out its duties under this section.

23                        “(B)    DATA    SHARING.—MACPAC    and  
 24        MedPAC shall have unrestricted access to all  
 25        deliberations, records, and nonproprietary data

1 of the other such entity, respectively, imme-  
 2 diately upon the request of the either such enti-  
 3 ty.”.

4 (d) RULE OF CONSTRUCTION.—Nothing in this sec-  
 5 tion—

6 (1) requires mandatory integrated care under  
 7 the Medicare or Medicaid programs under titles  
 8 XVIII and XIX, respectively, of the Social Security  
 9 Act;

10 (2) promotes enrollment in specialized MA  
 11 plans for special needs individuals (as defined in sec-  
 12 tion 1859(b)(6) of the Social Security Act (42  
 13 U.S.C. 1395w–28(b)(6)));

14 (3) promotes the development of Medicaid man-  
 15 aged care for dual eligible individuals; or

16 (4) prevents dual eligible individuals from elect-  
 17 ing to remain in the original Medicare fee-for-service  
 18 option, or the right to make such election being pro-  
 19 tected.

20 **SEC. 102. CREATING A MEDICARE OPERATED PRESCRIP-**  
 21 **TION DRUG PLAN OPTION.**

22 (a) MEDICARE OPERATED PRESCRIPTION DRUG  
 23 PLAN OPTION.—

24 (1) IN GENERAL.—Subpart 2 of part D of the  
 25 Social Security Act is amended by inserting after

1 section 1860D–11 (42 U.S.C. 1395w–111) the fol-  
 2 lowing new section:

3 “MEDICARE OPERATED PRESCRIPTION DRUG PLAN  
 4 OPTION

5 “SEC. 1860D–11A. (a) IN GENERAL.—Notwith-  
 6 standing any other provision of this part, for each year  
 7 (beginning with 2011), in addition to any plans offered  
 8 under section 1860D–11, the Secretary shall offer one or  
 9 more Medicare operated prescription drug plans (as de-  
 10 fined in subsection (b)) with a service area that consists  
 11 of the entire United States and shall enter into negotia-  
 12 tions in accordance with section 1860D–11A(i) with phar-  
 13 maceutical manufacturers to reduce the purchase cost of  
 14 covered part D drugs for eligible part D individuals who  
 15 enroll in such a plan.

16 “(b) MEDICARE OPERATED PRESCRIPTION DRUG  
 17 PLAN DEFINED.—For purposes of this part, the term  
 18 ‘Medicare operated prescription drug plan’ means a pre-  
 19 scription drug plan that offers qualified prescription drug  
 20 coverage and access to negotiated prices described in sec-  
 21 tion 1860D–2(a)(1)(A).

22 “(c) MONTHLY BENEFICIARY PREMIUM.—

23 “(1) QUALIFIED PRESCRIPTION DRUG COV-  
 24 ERAGE.—The monthly beneficiary premium for  
 25 qualified prescription drug coverage and access to  
 26 negotiated prices described in section 1860D–

1       2(a)(1)(A) to be charged under a Medicare operated  
 2       prescription drug plan shall be uniform nationally.  
 3       Such premium for months in 2010 and each suc-  
 4       ceeding year shall be equal to the product of—

5               “(A) the beneficiary premium percentage  
 6               (as specified in section 1860D–13(a)(3)); and

7               “(B) the average monthly per capita actu-  
 8               arial cost of offering the Medicare operated pre-  
 9               scription drug plan for the year involved, in-  
 10              cluding administrative expenses.

11             “(2) PREMIUM SUBSIDY FOR APPLICABLE SUB-  
 12             SIDY ELIGIBLE INDIVIDUALS.—

13               “(A) FULL SUBSIDY ELIGIBLE INDIVID-  
 14               UALS.—In the case of an applicable subsidy eli-  
 15               gible individual described in paragraph (4)(A),  
 16               the individual is entitled under this section to  
 17               an income-related premium subsidy equal to  
 18               100 percent of the monthly beneficiary pre-  
 19               mium of the Medicare operated prescription  
 20               drug plan.

21               “(B) OTHER SUBSIDY ELIGIBLE INDIVID-  
 22               UALS.—In the case of an applicable subsidy eli-  
 23               gible individual described in paragraph (4)(B),  
 24               the individual is entitled under this section to

an income-related premium subsidy determined  
on a linear sliding scale as follows:

“(i) One hundred percent of the  
amount described in subparagraph (A) for  
individuals with incomes at or below 135  
percent of such level.

“(ii) Seventy-five percent of such  
amount for individuals with incomes above  
135 percent of such level and at or below  
140 percent of such level.

“(iii) Fifty percent of such amount for  
individuals with incomes above 140 percent  
of such level and at or below 145 percent  
of such level.

“(iv) Twenty-five percent of such  
amount for individuals with incomes above  
145 percent of such level and below 150  
percent of such level.

“(v) Zero percent of such amount for  
individuals with incomes at 150 percent of  
such level.

“(3) COST-SHARING FOR APPLICABLE SUBSIDY  
ELIGIBLE INDIVIDUALS.—

“(A) FULL-SUBSIDY ELIGIBLE INDIVID-  
UALS.—In the case of an applicable subsidy eli-

gible individual described in paragraph (4)(A),  
the provisions of section 1860D–14(a)(1) shall  
apply, except the premium subsidy under para-  
graph (2)(A) shall be substituted for the pre-  
mium subsidy under subparagraph (A) of such  
section 1860D–14(a)(1).

“(B) OTHER SUBSIDY ELIGIBLE INDIVID-  
UALS.—In the case of an applicable subsidy eli-  
gible individual described in paragraph (4)(B),  
the provisions of section 1860D–14(a)(2) shall  
apply, except the premium subsidy under para-  
graph (2)(B) shall be substituted for the pre-  
mium subsidy under subparagraph (A) of such  
section 1860D–14(a)(2).

“(4) DEFINITION OF APPLICABLE SUBSIDY ELI-  
GIBLE INDIVIDUALS.—For purposes of paragraphs  
(2) and (3), the term ‘applicable subsidy eligible in-  
dividual’ means the following:

“(A) FULL-SUBSIDY ELIGIBLE INDIVID-  
UALS.—

“(i) INDIVIDUALS WITH INCOME  
BELOW 135 PERCENT OF POVERTY LINE.—

Any individual who—

“(I) is enrolled in a Medicare op-  
erated prescription drug plan;

1 “(II) is determined to have in-  
 2 come that is below 135 percent of the  
 3 poverty line applicable to a family of  
 4 the size involved; and

5 “(III) meets the resources re-  
 6 quirement described in section  
 7 1860D–14(a)(3)(E), as amended by  
 8 section 201 of the Medicare Prescrip-  
 9 tion Drug Coverage Improvement Act.

10 “(ii) CERTAIN OTHER INDIVIDUALS.—  
 11 Any individual who is enrolled in a Medi-  
 12 care operated prescription drug plan  
 13 who—

14 “(I) is a full-benefit dual eligible  
 15 individual (as defined in section  
 16 1935(c)(6));

17 “(II) receives benefits under the  
 18 supplemental security income program  
 19 under title XVI; or

20 “(III) is eligible for medical as-  
 21 sistance under clause (i), (iii), or (iv)  
 22 of section 1902(a)(10)(E).

23 “(B) OTHER SUBSIDY ELIGIBLE INDIVID-  
 24 UALS.—Any individual who—

25 “(i) is not described in paragraph (1);

1 “(ii) is enrolled in a Medicare oper-  
 2 ated prescription drug plan;

3 “(iii) is determined to have income  
 4 that is below 150 percent of the poverty  
 5 line applicable to a family of the size in-  
 6 volved; and

7 “(iv) meets the resources requirement  
 8 described in section 1860D–14(a)(3)(E),  
 9 as amended by section 201 of the Medicare  
 10 Prescription Drug Coverage Improvement  
 11 Act.

12 “(d) USE OF A FORMULARY AND FORMULARY IN-  
 13 CENTIVES.—

14 “(1) USE OF A FORMULARY.—

15 “(A) IN GENERAL.—With respect to the  
 16 operation of a Medicare operated prescription  
 17 drug plan, the Secretary shall establish and  
 18 apply a formulary (and may include formulary  
 19 incentives described in paragraph (5)(C)(ii)) in  
 20 accordance with this subsection in order to—

21 “(i) increase patient safety;

22 “(ii) increase appropriate use and re-  
 23 duce inappropriate use of drugs; and

24 “(iii) reward value.



1 “(B) DEFAULT INITIAL FORMULARY.—

2 Until such time as the Secretary establishes  
 3 and applies the initial formulary under para-  
 4 graph (5), a Medicare operated prescription  
 5 drug plan shall be required to include all drugs  
 6 approved for safety and effectiveness as a pre-  
 7 scription drug under the Federal Food, Drug,  
 8 and Cosmetic Act that are covered part D  
 9 drugs (and may include formulary incentives  
 10 described in paragraph (5)(C)(ii)).

11 “(2) REQUIREMENTS FOR FORMULARIES.—The  
 12 Secretary shall establish a formulary that meets the  
 13 following requirements:

14 “(A) Except as provided in subparagraph  
 15 (B), the formulary includes the covered out-  
 16 patient drugs of any manufacturer which has  
 17 entered into and complies with an agreement  
 18 with the Secretary under this section.

19 “(B) A covered outpatient drug may be ex-  
 20 cluded with respect to the treatment of a spe-  
 21 cific disease or condition for an identified popu-  
 22 lation (if any) only if, based on the drug’s label-  
 23 ing (or, in the case of a drug the prescribed use  
 24 of which is not approved under the Federal  
 25 Food, Drug, and Cosmetic Act but is a medi-

1 cally accepted indication (as defined in section  
 2 1860D–2(e)(4))), the excluded drug does not  
 3 have a significant, clinically meaningful thera-  
 4 peutic advantage in terms of safety, effective-  
 5 ness, or clinical outcome of such treatment for  
 6 such population over other drugs included in  
 7 the formulary and there is a written expla-  
 8 nation (available to the public) of the basis for  
 9 the exclusion.

10 “(C) The Secretary permits coverage of a  
 11 drug excluded from the formulary pursuant to  
 12 a prior authorization program that is consistent  
 13 with paragraph (3).

14 “(D) The formulary meets such other re-  
 15 quirements as the Secretary may impose in  
 16 order to achieve program savings consistent  
 17 with protecting the health of program bene-  
 18 ficiaries.

19 A prior authorization program established under  
 20 paragraph (3) is not a formulary subject to the re-  
 21 quirements of this paragraph.

22 “(3) REQUIREMENTS OF PRIOR AUTHORIZATION  
 23 PROGRAMS.—The Secretary may require, with re-  
 24 spect to drugs dispensed on or after July 1, 1991,  
 25 the approval of the drug before its dispensing for

1 any medically accepted indication (as defined in sec-  
2 tion 1860D–2(e)(4)) only if the system providing for  
3 such approval—

4 “(A) provides response by telephone or  
5 other telecommunication device within 24 hours  
6 of a request for prior authorization; and

7 “(B) provides for the dispensing of at least  
8 a 72-hour supply of a covered outpatient pre-  
9 scription drug in an emergency situation (as de-  
10 fined by the Secretary).

11 “(4) OTHER PERMISSIBLE RESTRICTIONS.—The  
12 Secretary may impose limitations, with respect to all  
13 such drugs in a therapeutic class, on the minimum  
14 or maximum quantities per prescription or on the  
15 number of refills, if such limitations are necessary to  
16 improve patient safety, discourage waste, or address  
17 instances of fraud or abuse by individuals in any  
18 manner authorized under this Act.

19 “(5) DEVELOPMENT OF INITIAL FORMULARY.—

20 “(A) IN GENERAL.—In selecting covered  
21 part D drugs for inclusion in a formulary, the  
22 Secretary shall consider clinical benefit and  
23 price.

24 “(B) ROLE OF AHRQ.—The Director of the  
25 Agency for Healthcare Research and Quality

1 shall be responsible for assessing the clinical  
2 benefit of covered part D drugs and making  
3 recommendations to the Secretary regarding  
4 which drugs should be included in the for-  
5 mulary. In conducting such assessments and  
6 making such recommendations, the Director  
7 shall—

8 “(i) consider safety concerns including  
9 those identified by the Federal Food and  
10 Drug Administration;

11 “(ii) use available data and evalua-  
12 tions, with priority given to randomized  
13 controlled trials, to examine clinical effec-  
14 tiveness, comparative effectiveness, safety,  
15 and enhanced compliance with a drug regi-  
16 men;

17 “(iii) use the same classes of drugs  
18 developed by United States Pharmacopeia  
19 for this part;

20 “(iv) consider evaluations made by—

21 “(I) the Director under section  
22 1013 of Medicare Prescription Drug,  
23 Improvement, and Modernization Act  
24 of 2003;

1 “(II) other Federal entities, such  
2 as the Secretary of Veterans Affairs;  
3 and

4 “(III) other private and public  
5 entities, such as the Drug Effective-  
6 ness Review Project and Medicaid  
7 programs; and

8 “(v) recommend to the Secretary—

9 “(I) those drugs in a class that  
10 provide a greater clinical benefit, in-  
11 cluding fewer safety concerns or less  
12 risk of side-effects, than another drug  
13 in the same class that should be in-  
14 cluded in the formulary;

15 “(II) those drugs in a class that  
16 provide less clinical benefit, including  
17 greater safety concerns or a greater  
18 risk of side-effects, than another drug  
19 in the same class that should be ex-  
20 cluded from the formulary; and

21 “(III) drugs in a class with same  
22 or similar clinical benefit for which it  
23 would be appropriate for the Sec-  
24 retary to competitively bid (or nego-  
25 tiate) for placement on the formulary.

“(C) CONSIDERATION OF AHRQ RECOMMENDATIONS.—

“(i) IN GENERAL.—Not later than January 1, 2011, the Secretary, after taking into consideration the recommendations under subparagraph (B)(v), shall establish a formulary, and formulary incentives, to encourage use of covered part D drugs that—

“(I) have a lower cost and provide a greater clinical benefit than other drugs;

“(II) have a lower cost than other drugs with same or similar clinical benefit; and

“(III) drugs that have the same cost but provide greater clinical benefit than other drugs.

“(ii) FORMULARY INCENTIVES.—The formulary incentives under clause (i) may be in the form of one or more of the following:

“(I) Tiered copayments.

“(II) Prior authorization.

“(III) Step therapy.

1 “(IV) Medication therapy man-  
2 agement.

3 “(V) Generic drug substitution.

4 “(iii) FLEXIBILITY.—In applying such  
5 formulary incentives the Secretary may de-  
6 cide not to impose any cost-sharing for a  
7 covered part D drug for which—

8 “(I) the elimination of cost shar-  
9 ing would be expected to increase  
10 compliance with a drug regimen; and

11 “(II) compliance would be ex-  
12 pected to produce savings under part  
13 A or B or both.

14 “(iv) DEVELOPMENT OF TRANS-  
15 PARENT PROCESS TO EXPLAIN FORMULARY  
16 INCENTIVES.—Not later than January 1,  
17 2011, the Secretary shall develop and im-  
18 plement a transparent process to identify  
19 and explain to beneficiaries formulary in-  
20 centives under clause (i). Such process  
21 shall be designed to assist beneficiaries in  
22 understanding how prior authorization re-  
23 quests and other formulary incentives will  
24 be evaluated.

1           “(6) LIMITATIONS ON FORMULARY.—In any  
2           formulary established under this subsection, the for-  
3           mulary may not be changed during a year, except—

4                   “(A) to add a generic version of a covered  
5           part D drug that entered the market;

6                   “(B) to remove such a drug for which a  
7           safety problem is found; and

8                   “(C) to add a drug that the Secretary  
9           identifies as a drug which treats a condition for  
10          which there has not previously been a treatment  
11          option or for which a clear and significant ben-  
12          efit has been demonstrated over other covered  
13          part D drugs.

14          “(7) ADDING DRUGS TO THE INITIAL FOR-  
15          MULARY.—

16                   “(A) USE OF ADVISORY COMMITTEE.—The  
17          Secretary shall establish and appoint an advi-  
18          sory committee (in this paragraph referred to  
19          as the ‘advisory committee’)—

20                           “(i) to review petitions from drug  
21                           manufacturers, health care provider orga-  
22                           nizations, patient groups, and other enti-  
23                           ties for inclusion of a drug in, or other  
24                           changes to, such formulary; and



1 “(ii) to recommend any changes to the  
2 formulary established under this sub-  
3 section.

4 “(B) COMPOSITION.—The advisory com-  
5 mittee shall be composed of 9 members and  
6 shall include representatives of physicians,  
7 pharmacists, and consumers and others with ex-  
8 pertise in evaluating prescription drugs. The  
9 Secretary shall select members based on their  
10 knowledge of pharmaceuticals and the Medicare  
11 and Medicaid populations. Members shall be  
12 deemed to be special Government employees for  
13 purposes of applying the conflict of interest pro-  
14 visions under section 208 of title 18, United  
15 States Code, and no waiver of such provisions  
16 for such a member shall be permitted.

17 “(C) CONSULTATION.—The advisory com-  
18 mittee shall consult, as necessary, with physi-  
19 cians who are specialists in treating the disease  
20 for which a drug is being considered.

21 “(D) REQUEST FOR STUDIES.—The advi-  
22 sory committee may request the Agency for  
23 Healthcare Research and Quality or an aca-  
24 demic or research institution to study and make

1 a report on a petition described in subpara-  
2 graph (A)(ii) in order to assess—

3 “(i) clinical effectiveness;

4 “(ii) comparative effectiveness;

5 “(iii) safety; and

6 “(iv) enhanced compliance with a  
7 drug regimen.

8 “(E) RECOMMENDATIONS.—The advisory  
9 committee shall make recommendations to the  
10 Secretary regarding—

11 “(i) whether a covered part D drug is  
12 found to provide a greater clinical benefit,  
13 including fewer safety concerns or less risk  
14 of side-effects, than another drug in the  
15 same class that is currently included in the  
16 formulary and should be included in the  
17 formulary;

18 “(ii) whether a covered part D drug is  
19 found to provide less clinical benefit, in-  
20 cluding greater safety concerns or a great-  
21 er risk of side-effects, than another drug in  
22 the same class that is currently included in  
23 the formulary and should not be included  
24 in the formulary; and

1                   “(iii) whether a covered part D drug  
2                   has the same or similar clinical benefit to  
3                   a drug in the same class that is currently  
4                   included in the formulary and whether the  
5                   drug should be included in the formulary.

6                   “(F) LIMITATIONS ON REVIEW OF MANU-  
7                   FACTURER PETITIONS.—The advisory com-  
8                   mittee shall not review a petition of a drug  
9                   manufacturer under subparagraph (A)(ii) with  
10                  respect to a covered part D drug unless the pe-  
11                  tition is accompanied by the following:

12                   “(i) Raw data from clinical trials on  
13                   the safety and effectiveness of the drug.

14                   “(ii) Any data from clinical trials con-  
15                   ducted using active controls on the drug or  
16                   drugs that are the current standard of  
17                   care.

18                   “(iii) Any available data on compara-  
19                   tive effectiveness of the drug.

20                   “(iv) Any other information the Sec-  
21                   retary requires for the advisory committee  
22                   to complete its review.

23                   “(G) RESPONSE TO RECOMMENDATIONS.—  
24                   The Secretary shall review the recommenda-  
25                   tions of the advisory committee and if the Sec-

1           retary accepts such recommendations the Sec-  
2           retary shall modify the formulary established  
3           under this subsection accordingly. Nothing in  
4           this section shall preclude the Secretary from  
5           adding to the formulary a drug for which the  
6           Director of the Agency for Healthcare Research  
7           and Quality or the advisory committee has not  
8           made a recommendation.

9           “(H) NOTICE OF CHANGES.—The Sec-  
10          retary shall provide timely notice to bene-  
11          ficiaries and health professionals about changes  
12          to the formulary or formulary incentives.

13          “(I) STABILITY OF BENEFIT.—Once a cov-  
14          ered part D drug has been added to the for-  
15          mulary established under this subsection, the  
16          drug may not be removed from the formulary  
17          for at least a 3-year period, unless the Sec-  
18          retary determines there are safety or efficacy  
19          concerns with respect to the drug.

20          “(8) NON-EXCLUDABLE DRUGS.—The following  
21          drugs or classes of drugs shall not be excluded from  
22          the default initial formulary (as described in para-  
23          graph (1)(B)) or the initial formulary established by  
24          the Secretary (as described in paragraph (5)):

25               “(A) Barbiturates.

1 “(B) Benzodiazepines.

2 “(e) INFORMING BENEFICIARIES.—

3 “(1) IN GENERAL.—The Secretary shall take  
4 steps to inform beneficiaries about the availability of  
5 a Medicare operated prescription drug plan or plans  
6 including providing information in the annual hand-  
7 book distributed to all beneficiaries and adding in-  
8 formation to the official public Medicare website re-  
9 lated to prescription drug coverage available through  
10 this part.

11 “(2) SOLE RESPONSIBILITY FOR MARKETING BY  
12 THE SECRETARY.—

13 “(A) IN GENERAL.—The Secretary shall  
14 have sole responsibility for marketing Medicare  
15 operated prescription drug plans.

16 “(B) AUTHORIZATION.—There is author-  
17 ized to be appropriated to the Secretary such  
18 sums as are necessary to carry out such mar-  
19 keting.

20 “(f) APPLICATION OF ALL OTHER REQUIREMENTS  
21 FOR PRESCRIPTION DRUG PLANS.—Except as specifically  
22 provided in this section, any Medicare operated drug plan  
23 shall meet the same requirements as apply to any other  
24 prescription drug plan, including the requirements of sec-  
25 tion 1860D–4(b)(1) relating to assuring pharmacy access.

1       “(g) AUTOMATIC ENROLLMENT.—The Secretary  
 2 shall establish procedures to provide for the automatic en-  
 3 rollment of subsidy eligible individuals (as defined in sec-  
 4 tion 1860D–14(a)(3)) in a Medicare operated prescription  
 5 drug plan in the case where such individuals lose their  
 6 current prescription drug coverage, become part D eligible  
 7 individuals, or in instances where the amount of the  
 8 monthly beneficiary premium under the prescription drug  
 9 plan the individual is enrolled in is greater than the pre-  
 10 mium subsidy amount described in section 1860D–14(b).

11       “(h) RULE OF CONSTRUCTION REGARDING ELIGI-  
 12 BILITY FOR MEDICAL ASSISTANCE.—In no case may en-  
 13 rollment in a Medicare operated prescription drug plan af-  
 14 fect the eligibility of an individual to receive medical as-  
 15 sistance under a State plan under title XIX.”.

16           (2) EFFECTIVE DATE.—The amendment made  
 17 by this subsection shall take effect as if included in  
 18 the enactment of section 101 of the Medicare Pre-  
 19 scription Drug, Improvement, and Modernization  
 20 Act of 2003.

21       (b) CONFORMING AMENDMENTS.—

22           (1) IN GENERAL.—

23                   (A) Section 1860D–3(a) of the Social Se-  
 24 curity Act (42 U.S.C. 1395w–103(a)) is amend-

1           ed by adding at the end the following new para-  
2           graph:

3           “(4) AVAILABILITY OF THE MEDICARE OPER-  
4           ATED PRESCRIPTION DRUG PLAN.—A Medicare op-  
5           erated prescription drug plan (as defined in section  
6           1860D–11A(c)) shall be offered nationally in accord-  
7           ance with section 1860D–11A.”.

8           (B)(i) Section 1860D–3 of the Social Secu-  
9           rity Act (42 U.S.C. 1395w–103) is amended by  
10          adding at the end the following new subsection:

11          “(c) PROVISIONS ONLY APPLICABLE IN 2006, 2007,  
12          2008, AND 2009.—The provisions of this section shall only  
13          apply with respect to 2006, 2007, 2008, and 2009.”.

14          (C) Section 1860D–11(g) of such Act (42  
15          U.S.C. 1395w–111(g)) is amended by adding at  
16          the end the following new paragraph:

17          “(8) NO AUTHORITY FOR FALLBACK PLANS  
18          AFTER 2009.—A fallback prescription drug plan shall  
19          not be available after December 31, 2009.”.

20          (D) Section 1860D–13(c)(3) of such Act  
21          (42 U.S.C. 1395w–113(c)(3)) is amended—

22                 (i) in the heading, by inserting “AND  
23                 MEDICARE OPERATED PRESCRIPTION DRUG  
24                 PLANS” after “FALLBACK PLANS”; and

1 (ii) by inserting “or a Medicare oper-  
 2 ated prescription drug plan” after “a fall-  
 3 back prescription drug plan”.

4 (E) Section 1860D–14(a) of the Social Se-  
 5 curity Act (42 U.S.C. 1395w–114(a)) is amend-  
 6 ed—

7 (i) in paragraph (1), by striking “In  
 8 the” and inserting “Subject to section  
 9 1860D–11A(c)(2)(A), in the”; and

10 (ii) in paragraph (2), by striking “In  
 11 the” and inserting “Subject to section  
 12 1860D–11A(c)(2)(B), in the”.

13 (F) Section 1860D–16(b)(1) of such Act  
 14 (42 U.S.C.1395w–116(b)(1)) is amended—

15 (i) in subparagraph (C), by striking  
 16 “and” after the semicolon at the end;

17 (ii) in subparagraph (D), by striking  
 18 the period at the end and inserting “;  
 19 and”; and

20 (G) by adding at the end the following new  
 21 subparagraph:

22 “(E) payments for expenses incurred with  
 23 respect to the operation of Medicare operated  
 24 prescription drug plans under section 1860D–  
 25 11A.”.



1 (H) Section 1860D–41(a) of such Act (42  
 2 U.S.C. 1395w–151(a)) is amended by adding at  
 3 the end the following new paragraph:

4 “(19) MEDICARE OPERATED PRESCRIPTION  
 5 DRUG PLAN.—The term ‘Medicare operated prescrip-  
 6 tion drug plan’ has the meaning given such term in  
 7 section 1860D–11A(c).”.

8 (2) EFFECTIVE DATE.—The amendments made  
 9 by this subsection shall take effect as if included in  
 10 the enactment of section 101 of the Medicare Pre-  
 11 scription Drug, Improvement, and Modernization  
 12 Act of 2003.

13 **SEC. 103. ACCREDITATION REQUIREMENT FOR ALL SPE-**  
 14 **CIALIZED MEDICARE ADVANTAGE PLANS**  
 15 **AND REVISIONS RELATING TO SPECIALIZED**  
 16 **MEDICARE ADVANTAGE PLANS FOR SPECIAL**  
 17 **NEEDS INDIVIDUALS.**

18 (a) ACCREDITATION REQUIREMENT.—Section  
 19 1859(f) of the Social Security Act (42 U.S.C. 1395w–  
 20 28(f)) is amended—

21 (1) in paragraphs (2)(B), (3)(B), and (4)(B),  
 22 by striking “paragraph (5)” and inserting “para-  
 23 graphs (5) and (6)(B)” each place it appears; and

24 (2) by adding at the end the following new  
 25 paragraph:

1           “(6) ACCREDITATION REQUIREMENT FOR ALL  
2       SNPS.—

3           “(A) ESTABLISHMENT OF ACCREDITATION  
4       PROGRAM.—Not later than January 1, 2011,  
5       the Secretary, acting through the Director of  
6       the Agency for Healthcare Research and Qual-  
7       ity and the Administrator of the Centers for  
8       Medicare & Medicaid Services, shall enter into  
9       a contract with the National Committee for  
10      Quality Assurance under which the National  
11      Committee for Quality Assurance shall develop  
12      an accreditation (and reaccreditation) program  
13      for all specialized MA plans for special needs  
14      individuals (as defined in subsection (b)(6)), in-  
15      cluding specialized MA plans for special needs  
16      individuals described in subsection (b)(6)(B)(ii).

17          “(B) REQUIREMENT.—The requirement  
18      described in this subparagraph is that, effective  
19      for plan years beginning on or after January 1,  
20      2012, a specialized MA plan for special needs  
21      individuals (as so defined) meet the accredita-  
22      tion standards developed by the National Com-  
23      mittee for Quality Assurance under the contract  
24      under subparagraph (A).”.

1 (b) REVISIONS RELATING TO SPECIALIZED MEDI-  
 2 CARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVID-  
 3 UALS.—Section 1859 of the Social Security Act (42  
 4 U.S.C. 1395w–28) is amended—

5 (1) in subsection (f)(3)—

6 (A) in subparagraph (D), in the first sen-  
 7 tence, by inserting “and the plan provides for  
 8 the coordination of coverage for benefits under  
 9 this title (including this part) and such medical  
 10 assistance” before the period at the end; and

11 (B) by adding at the end the following new  
 12 subparagraph:

13 “(E) The plan meets the requirements de-  
 14 scribed in subsection (g).”; and

15 (2) by adding at the end the following new sub-  
 16 section:

17 “(g) ADDITIONAL REQUIREMENTS FOR DUAL  
 18 SNPS.—The following requirements are described in this  
 19 subsection:

20 “(1) PROVISION OF INFORMATION.—The plan  
 21 provides special needs individuals described in sub-  
 22 section (b)(6)(B)(ii) up-front information about  
 23 formularies and utilization management strategies  
 24 under the plan as part of the information disclosed  
 25 under section 1852(c)(1).

1           “(2) PREMIUM.—The premium under the plan  
2           does not exceed the premium subsidy amount de-  
3           scribed in section 1860D–14(b).

4           “(3) FORMULARY.—

5                 “(A) IN GENERAL.—Subject to subpara-  
6                 graph (B), the plan has a formulary that, based  
7                 on the most recent data available, covers at  
8                 least—

9                         “(i) 95 percent of the 200 most com-  
10                        monly prescribed non-duplicative generic  
11                        covered part D drugs for the population of  
12                        individuals entitled to (or enrolled for) ben-  
13                        efits under part A or enrolled under part  
14                        B; and

15                       “(ii) 95 percent of the 200 most com-  
16                        monly prescribed non-duplicative brand  
17                        name covered part D drugs for such popu-  
18                        lation.

19                 “(B) INCLUSION OF DRUGS IN CERTAIN  
20                 CATEGORIES AND CLASSES.—The plan for-  
21                 mulary shall include all covered part D drugs in  
22                 the categories and classes identified by the Sec-  
23                 retary under section 1860D–4(b)(3)(G)(i).

24           “(4) PHARMACY ACCESS.—The plan secures  
25           participation in its network of a sufficient number of

1 pharmacies that dispense (other than by mail order)  
 2 drugs directly to patients to ensure convenient ac-  
 3 cess by at least 90 percent of enrollees who are re-  
 4 siding in long-term care facilities within the region.

5 “(5) OPERATION OF A DEDICATED CUSTOMER  
 6 ASSISTANCE PHONE LINE.—The plan shall maintain  
 7 a toll-free number or numbers for inquiries con-  
 8 cerning the plan that is solely for the use of such  
 9 individuals, the designated representatives of such  
 10 individuals (including designated family members),  
 11 advocates of such individuals, providers of services,  
 12 and suppliers.

13 “(6) E-PRESCRIBING.—The plan adopts elec-  
 14 tronic prescribing for enrollees, in accordance with  
 15 section 1860D–4(e), to coordinate care.

16 “(7) DEMONSTRATE EXPERIENCE AND EXPER-  
 17 TISE.—The plan demonstrates, to the satisfaction of  
 18 the Secretary, with input from the States, sufficient  
 19 experience and expertise in serving low-income, pub-  
 20 licly insured, or previously uninsured populations.

21 “(8) REDUCING HEALTH DISPARITIES.—The  
 22 plan has established and implemented systems and  
 23 processes which have been approved by the Secretary  
 24 to address and reduce health disparities based on

1 race, ethnicity, gender, age, and socio-economic sta-  
 2 tus.

3 “(9) PROFICIENCY IN CARE COORDINATION.—

4 The plan demonstrates, to the satisfaction of the  
 5 Secretary, proficiency in care coordination for the  
 6 purpose of providing, or arranging for the provision  
 7 of, services to assist individuals enrolled in the plan  
 8 in obtaining access to other public and private bene-  
 9 fits, including services to address non-medical and  
 10 psycho-social needs.”.

11 (c) EFFECTIVE DATE.—The amendments made by  
 12 this section shall apply to plan year beginning on or after  
 13 January 1, 2011.

14 **SEC. 104. PROVIDING BETTER CARE COORDINATION FOR**  
 15 **LOW-INCOME BENEFICIARIES IN MEDICARE**  
 16 **PART D.**

17 (a) CONTINUOUS UPDATING OF ELIGIBILITY AND  
 18 ENROLLMENT DATA FOR DUAL ELIGIBLE INDIVID-  
 19 UALS.—

20 (1) STATE REQUIREMENT.—Section 1935(a) of  
 21 the Social Security Act (42 U.S.C. 1396u–5(a)) is  
 22 amended by adding at the end the following new  
 23 paragraph:

24 “(4) UPDATING OF ELIGIBILITY AND ENROLL-  
 25 MENT INFORMATION ON A ROLLING BASIS.—Begin-

1       ning not later than October 1, 2011, the State shall  
 2       update information with respect to the eligibility and  
 3       enrollment of individuals receiving any kind of med-  
 4       ical assistance under the State plan, including med-  
 5       ical assistance for payment of Medicare cost-sharing  
 6       described in section 1905(p)(3), in MA plans and  
 7       prescription drug plans under parts C and D, re-  
 8       spectively, of title XVIII (including eligibility deter-  
 9       minations under paragraph (2) and screening and  
 10      enrollment under paragraph (3)) not less frequently  
 11      than on a weekly basis.”.

12           (2) SECRETARIAL REQUIREMENTS.—Section  
 13      1935(d) of the Social Security Act (42 U.S.C.  
 14      1396u–5(d)) is amended by adding at the end the  
 15      following new paragraph:

16           “(3) UPDATING OF ELIGIBILITY AND ENROLL-  
 17      MENT INFORMATION ON A ROLLING BASIS.—The  
 18      Secretary shall update information with respect to  
 19      the eligibility and enrollment of individuals receiving  
 20      any kind of medical assistance under this title, in-  
 21      cluding medical assistance for payment of Medicare  
 22      cost-sharing described in section 1905(p)(3), in MA  
 23      plans and prescription drug plans under parts C and  
 24      D, respectively, of title XVIII as it is received, but  
 25      not less frequently than on a weekly basis.”.

1 (b) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN  
2 DATA RECORDS.—

3 (1) IN GENERAL.—Section 1859 of the Social  
4 Security Act (42 U.S.C. 1305w-28), as amended by  
5 section 103, is amended by adding at the end the  
6 following new subsection:

7 “(h) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN  
8 DATA RECORDS.—

9 “(1) IDENTIFICATION BY THE SECRETARY.—  
10 Beginning on January 1, 2010, the Secretary shall  
11 clearly identify all dual eligible individuals that are  
12 enrolled in MA plans and prescription drug plans for  
13 the current plan year and reflect the low-income  
14 subsidy status of such individuals for each plan year  
15 in every data record file maintained in the Medicare  
16 electronic database and every such file that is used  
17 to enroll or adjudicate claims for such individuals.

18 “(2) IDENTIFICATION BY MA PLANS AND PRE-  
19 SCRIPTIION DRUG PLANS.—Beginning on January 1,  
20 2010, each MA plan and prescription drug plan shall  
21 clearly identify all dual eligible individuals that are  
22 enrolled in the plan for the current plan year and re-  
23 flect the low-income subsidy status of such individ-  
24 uals for the plan year in every data record file main-



1       tained by the plan that is used to enroll or adju-  
 2       dicate claims for such individuals under the plan.

3           “(3) REGULATIONS.—The Secretary shall es-  
 4       tablish regulations to carry out this subsection. Such  
 5       regulations shall require that—

6           “(A) for each plan year and each dual eli-  
 7       gible individual, the Secretary identify on the  
 8       Medicare enrollment database dual eligible sta-  
 9       tus that has been verified with a State or the  
 10      District of Columbia;

11          “(B) for each plan year and each dual eli-  
 12      gible individual, the Secretary identify on the  
 13      Medicare enrollment database the low-income  
 14      subsidy level of the individual; and

15          “(C) each data file that is necessary to en-  
 16      sure that such dual eligible status is trans-  
 17      mitted to an MA plan or a prescription drug  
 18      plan, at the time the Secretary certifies the en-  
 19      rollment of the dual eligible individual in the  
 20      plan.

21          “(4) DEFINITION OF DUAL ELIGIBLE INDIVIDUAL.—The term ‘dual eligible individual’ means  
 22      a special needs individual described in subsection  
 23      (b)(6)(B)(ii).”.

1           (2)     CONFORMING     AMENDMENT.—Section  
 2     1860D–42 of the Social Security Act (42 U.S.C.  
 3     1395w–152) is amended by adding at the end the  
 4     following new subsection:

5     “(c) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN  
 6     DATA RECORDS.—For provisions regarding the identifica-  
 7     tion by prescription drug plans of dual eligible individuals  
 8     in data records, see section 1859(h).”.

9     (c) ASSURING CONTINUITY OF PRESCRIPTION DRUG  
 10    COVERAGE FOR DUAL ELIGIBLES.—

11           (1) IN GENERAL.—Section 1935(d)(1) of the  
 12    Social Security Act (42 U.S.C. 1396u–5(d)(1)) is  
 13    amended—

14                (A) by inserting “on and after the date de-  
 15                scribed in subparagraph (B),” after “notwith-  
 16                standing any other provision of this title,”;

17                (B) by striking “In the case of” and in-  
 18                serting the following:

19                       “(A) IN GENERAL.—In the case of”; and

20                       (C) by adding at the end the following:

21                       “(B) DATE DESCRIBED.—For purposes of  
 22                       subparagraph (A), the date described in this  
 23                       subparagraph is the date on which the State  
 24                       confirms with a Medicare Advantage plan under  
 25                       part C of title XVIII or a prescription drug

plan under part D of such title (including a Medicare operated prescription drug plan under section 1860D–11A), as applicable—

“(i) that the part D eligible individual (as so defined) who is described in subsection (c)(6)(A)(ii) is enrolled with such plan; and

“(ii) the cost-sharing and premiums applicable for the individual for such plan.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on January 1, 2011.

(d) COLLECTION AND SHARING OF DRUG UTILIZATION DATA AND FORMULARY INFORMATION FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–42 of the Social Security Act, as amended by subsection (b), is amended by adding at the end the following new subsection:

“(d) COLLECTION AND SHARING OF DRUG UTILIZATION DATA AND FORMULARY INFORMATION FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

“(1) PLAN REQUIREMENT.—A PDP sponsor of a prescription drug plan (including a Medicare operated prescription drug plan under section 1860D–

1 11A) and an MA organization offering an MA–PD  
 2 plan shall submit to the Secretary such information  
 3 regarding the drug utilization of enrollees in such  
 4 plans who are full-benefit dual eligible individuals  
 5 (as defined in section 1935(c)(6)) and any  
 6 formularies under the plans such individuals are en-  
 7 rolled in as the Secretary determines appropriate to  
 8 carry out paragraph (2). Such information shall be  
 9 submitted—

10 “(A) on a rolling basis (as determined ap-  
 11 propriate by the Secretary); and

12 “(B) using a single, uniform reporting  
 13 process.

14 “(2) COLLECTION AND SHARING OF DATA.—

15 The Secretary shall collect data on the drug utiliza-  
 16 tion of full-benefit dual eligible individuals (as so de-  
 17 fined) and on any formularies under the plans such  
 18 individuals are enrolled in. The Secretary shall share  
 19 such data with the States and the District of Colum-  
 20 bia on as close to a real-time basis as possible.”.

21 (2) EFFECTIVE DATE.—The amendment made  
 22 by paragraph (1) shall take effect on January 1,  
 23 2010.

1 **SEC. 105. IMPROVING TRANSITION OF NEW DUAL ELIGIBLE**  
2 **INDIVIDUALS TO MEDICARE PRESCRIPTION**  
3 **DRUG COVERAGE AND PRESUMPTIVE ELIGI-**  
4 **BILITY FOR LOW-INCOME SUBSIDIES.**

5 (a) UPDATING THE POINT OF SALE FACILITATED  
6 ENROLLMENT PROCESS.—

7 (1) PROVIDING BETTER INITIAL PROTECTION  
8 FOR DUAL ELIGIBLE INDIVIDUALS.—Beginning Jan-  
9 uary 1, 2011, each contractor under the Point of  
10 Sale Facilitated Enrollment process of the Depart-  
11 ment of Health and Human Services shall enroll  
12 full-benefit dual eligible individuals (as defined in  
13 section 1935(c)(6)) into a Medicare operated pre-  
14 scription drug plan under section 1860D–11A of the  
15 Social Security Act, as added by section 102.

16 (2) COMPETITIVE BIDDING OF POINT OF SALE  
17 CONTRACT.—The Secretary of Health and Human  
18 Services shall establish procedures to ensure that  
19 each contract entered into under such process on or  
20 after January 1, 2010, under the Medicare program  
21 under title XVIII of the Social Security Act is rebid  
22 every 3 years through a competitive bidding process.

23 (3) REQUIRING BETTER EDUCATION ABOUT  
24 POINT OF SALE FACILITATED ENROLLMENT PROC-  
25 ESS.—Not later than January 1, 2010, the Sec-  
26 retary of Health and Human Services shall have a

1 comprehensive plan in place for proactively edu-  
 2 cating beneficiaries under the Medicare prescription  
 3 drug program under part D of title XVIII of the So-  
 4 cial Security Act, pharmacists, skilled nursing facili-  
 5 ties (as defined in section 1819(a) of such Act (42  
 6 U.S.C. 1395i-3(a))), nursing facilities (as defined in  
 7 section 1919(a) of such Act (42 U.S.C. 1396r(a))),  
 8 counselors under State health insurance assistance  
 9 programs (SHIPs), and other advocacy organiza-  
 10 tions (including disability organizations) about the  
 11 Point of Sale Facilitated Enrollment process. Under  
 12 such plan—

13 (A) information about the Point of Sale  
 14 Facilitated Enrollment process shall be included  
 15 in all mailers to the entities and individuals de-  
 16 scribed in the preceding sentence prior to the  
 17 annual, coordinated election period described in  
 18 section 1851(e)(3) of the Social Security Act  
 19 (42 U.S.C. 1395w-21(e)(3)); and

20 (B) a description of such process and other  
 21 relevant information shall be prominently dis-  
 22 played on the Medicare Internet website  
 23 throughout the year.

24 (4) MANDATORY USE OF POINT OF SALE FA-  
 25 CILITATED ENROLLMENT PROCESS.—Section

1       1860D–4(b)(1) of the Social Security Act (42  
 2       U.S.C. 1395w–104(b)(1)) is amended by adding at  
 3       the end the following new subparagraph:

4               “(F) MANDATORY USE OF POINT OF SALE  
 5       FACILITATED ENROLLMENT PROCESS.—Not-  
 6       withstanding any other provision of law, begin-  
 7       ning January 1, 2011, the terms and conditions  
 8       under subparagraph (A) shall require partici-  
 9       pating pharmacies to use the Point of Sale Fa-  
 10      cilitated Enrollment process of the Department  
 11      of Health and Human Services.”.

12      (b) PRESUMPTIVE ELIGIBILITY AND MANDATORY  
 13      TRANSITION PERIOD FOR SUBSIDY ELIGIBLE INDIVID-  
 14      UALS.—Section 1860D–14 of the Social Security Act (42  
 15      U.S.C. 1395w–104) is amended—

16           (1) by redesignating subsection (d) as sub-  
 17      section (e); and

18           (2) by inserting after subsection (c) the fol-  
 19      lowing new subsection:

20           “(d) PRESUMPTIVE ELIGIBILITY AND MANDATORY  
 21      TRANSITION PERIOD.—

22           “(1) PRESUMPTIVE ELIGIBILITY.—An indi-  
 23      vidual shall be presumed to be a subsidy eligible in-  
 24      dividual (as defined in section 1860D–14(a)(3)) if  
 25      the individual presents at the pharmacy with—

1 “(A) reliable evidence of—

2 “(i) Medicaid enrollment, such as a  
3 Medicaid card, recent history of Medicaid  
4 billing in the pharmacy patient profile, a  
5 copy of a current Medicaid award letter, or  
6 confirmation from a Medicaid enrollment  
7 database; or

8 “(ii) eligibility for an income-related  
9 subsidy under section 1860D–14, such as  
10 a low-income subsidy notice from the Sec-  
11 retary or the Commissioner of Social Secu-  
12 rity, or confirmation from a Social Security  
13 enrollment database; and

14 “(B) reliable evidence of Medicare enroll-  
15 ment, such as a Medicare identification card, a  
16 Medicare enrollment approval letter, a Medicare  
17 Summary Notice, or confirmation from an offi-  
18 cial Medicare hotline or Medicare database.

19 “(2) MAKING SUBSIDY ELIGIBLE INDIVIDUALS  
20 WHOLE.—

21 “(A) IN GENERAL.—In the case of a sub-  
22 sidy eligible individual (as so defined) who, be-  
23 tween November 15, 2005, and December 31,  
24 2009, has wrongly been forced to pay higher co-  
25 payments, premiums, and deductibles than



1           those applicable under this part and part C for  
 2           such individual, the subsidy eligible individual  
 3           shall be eligible for compensation under the pro-  
 4           gram under this title.

5           “(B) ESTABLISHMENT OF PROCESS FOR  
 6           REFUND OF AMOUNT INCORRECTLY PAID.—The  
 7           Secretary shall establish a process under  
 8           which—

9                   “(i) prescription drug plans and MA–  
 10           PD plans are billed for copayments and  
 11           deductibles inappropriately charged to sub-  
 12           sidy eligible individuals during retroactive  
 13           coverage periods;

14                   “(ii) the amounts incorrectly paid by  
 15           the subsidy eligible individual as a result of  
 16           those inappropriate charges are refunded  
 17           directly to the individual, either through a  
 18           rebate on future payments of premiums  
 19           under part B or through a direct payment  
 20           to the individual; and

21                   “(iii) prescription drug plans and  
 22           MA–PD plans are required to provide de-  
 23           tailed accounting to the Secretary of the  
 24           basis for any rebate or payment to a sub-  
 25           sidy eligible individual under this subpara-

graph, including the applicable period of retroactive coverage for the subsidy eligible individual and whether the rebate or credit is with respect to an inappropriately charged copayment or deductible.

“(C) NOTIFICATION.—Subsidy eligible individuals shall be notified of the requirements of this subsection in their 2010 plan year materials.

“(D) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Amounts refunded to a subsidy eligible individual under this subsection shall be disregarded for purposes of determining or continuing the beneficiary’s eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI.”.

**SEC. 106. REQUIRED INFORMATION ON TRANSITION FROM SKILLED NURSING FACILITIES AND NURSING FACILITIES TO PART D PLANS.**

(a) SKILLED NURSING FACILITIES.—Section 1819(b) of the Social Security Act (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following new paragraph:

1           “(9) INFORMATION ON TRANSITION TO PRE-  
 2       SCRIPTION DRUG COVERAGE.—A skilled nursing fa-  
 3       cility must provide information to residents and the  
 4       families of residents on how to transition to pre-  
 5       scription drug coverage under MA–PD plans under  
 6       part C and prescription drug plans under part D  
 7       upon discharge from the facility.”.

8       (b) NURSING FACILITIES.—Section 1919(b) of the  
 9       Social Security Act (42 U.S.C. 1395i–3(b)) is amended  
 10      by adding at the end the following new paragraph:

11           “(9) INFORMATION ON TRANSITIONING TO PRE-  
 12       SCRIPTION DRUG COVERAGE.—A nursing facility  
 13       must provide information to residents and the fami-  
 14       lies of residents on how to transition to prescription  
 15       drug coverage under MA–PD plans under part C  
 16       and prescription drug plans under part D upon dis-  
 17       charge from the facility.”.

18       (c) EFFECTIVE DATE.—The amendments made by  
 19       this section shall take effect on January 1, 2011.

20      **SEC. 107. STREAMLINED PHARMACY COMPLIANCE PACK-**  
 21                                      **AGING.**

22       (a) IN GENERAL.—Section 1860D–4(b)(3) of the So-  
 23       cial Security Act (42 U.S.C. 1395w–104(b)(3)) is amend-  
 24       ed by adding at the end the following new subparagraph:

“(G) STREAMLINED PHARMACY COMPLI-  
 ANCE PACKAGING FOR DUAL ELIGIBLE INDIVID-  
 UALS.—A PDP sponsor of a prescription drug  
 plan shall streamline pharmacy compliance  
 packaging for individuals enrolled in the plan  
 who—

“(i) are entitled to medical assistance  
 under a State plan under title XVIII; and

“(ii) reside in a nursing home.”.

(b) EFFECTIVE DATE.—The amendments made by  
 subsection (a) shall apply to drugs dispensed on or after  
 January 1, 2010.

**SEC. 108. LOWERING COVERED PART D DRUG PRICES ON  
 BEHALF OF MEDICARE BENEFICIARIES.**

(a) REPEAL OF PROHIBITION.—Section 1860D–11 of  
 the Social Security Act (42 U.S.C. 1395w–111) is amend-  
 ed by striking subsection (i) and inserting the following:

“(i) LOWERING COVERED PART D DRUG PRICES.—

“(1) IN GENERAL.—The Secretary shall reduce  
 the purchase cost of covered part D drugs by imple-  
 menting 2 or more of the following strategies on an  
 annual basis (beginning with 2011):

“(A) Negotiating directly with pharma-  
 ceutical manufacturers for additional discounts,  
 rebates, and other price concessions that may

1 be made available to Medicare operated pre-  
2 scription drug plans under section 1860D–11A  
3 for covered part D drugs.

4 “(B) Entering into rebate agreements with  
5 manufacturers to provide to the Secretary a re-  
6 bate for any covered outpatient drug of a man-  
7 ufacturer dispensed during a rebate period  
8 specified in the agreement to a subsidy eligible  
9 individual described (or treated as described) in  
10 section 1860D–14(a)(1) for which payment was  
11 made by a PDP sponsor under part D of title  
12 XVIII or an MA organization under part C of  
13 such title for such period in an amount deter-  
14 mined in the same manner as the rebate  
15 amount for such drug would have been deter-  
16 mined under subsection (c) of section 1927 if  
17 the dispensing of the drug to such individual  
18 was paid for by a State and subject to a rebate  
19 agreement entered into under such section (and  
20 allocating any such rebates received among the  
21 prescription drug plans of such PDP sponsors  
22 and MA–PD plans offered by such organiza-  
23 tions based on the enrollment of such individ-  
24 uals in such plans).

“(C) In consultation with the Director of the Agency for Healthcare Research and Quality, using data from relevant and unbiased studies on the comparative clinical effectiveness of covered part D drugs to—

“(i) educate physicians and pharmacists; and

“(ii) provide information to PDP sponsors of prescription drug plans and MA organizations offering MA–PD plans for use in making decisions regarding plan formularies.

“(D) Instituting prescription drug prices negotiated under the Federal Supply Schedule of the General Services Administration for the reimbursement of covered part D drugs.

“(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated by the Secretary for a Medicare-operated plan under paragraph (1)(A).

1           “(3) ANNUAL REPORTS TO CONGRESS.—Not  
 2           later than January 1, 2012, and annually thereafter,  
 3           the Secretary shall submit to the Committee on Fi-  
 4           nance of the Senate and to the Committee on Ways  
 5           and Means, the Committee on Energy and Com-  
 6           merce, and the Committee on Oversight and Govern-  
 7           ment Reform of the House of Representatives a re-  
 8           port on the strategies implemented by the Secretary  
 9           under paragraph (1) to achieve lower prices on cov-  
 10          ered part D drugs for beneficiaries, including the  
 11          prices of such covered part D drugs and any price  
 12          concessions achieved by the Secretary as a result of  
 13          such implementation.”.

14 **SEC. 109. CORRECTION OF FLAWS IN DETERMINATION OF**  
 15                   **PHASED-DOWN STATE CONTRIBUTION FOR**  
 16                   **FEDERAL ASSUMPTION OF PRESCRIPTION**  
 17                   **DRUG COSTS FOR DUALY ELIGIBLE INDIVID-**  
 18                   **UALS.**

19           Section 1935(c) of the Social Security Act (42 U.S.C.  
 20   1396u–5(c)) is amended—

21           (1) in paragraph (1), in the matter preceding  
 22           subparagraph (A), by striking “Each” and inserting  
 23           “Subject to paragraph (7), each”; and

24           (2) by adding at the end the following new  
 25           paragraph:

1           “(7) MODIFICATION OF DETERMINATION OF  
2       AMOUNT OF STATE CONTRIBUTION.—Not later than  
3       January 1, 2011, the Secretary of Health and  
4       Human Services (in this section referred to as the  
5       ‘Secretary’), acting through the Director of the Fed-  
6       eral Coordinated Health Care Office established  
7       under section 101 of the Medicare Prescription Drug  
8       Reform Act of 2009, shall promulgate regulations  
9       for modifying the factors used to determine the  
10      product under paragraph (1)(A) for each State and  
11      month that take into account the following with re-  
12      spect to each State:

13           “(A) Factoring into the determination of  
14      base year State Medicaid per capita expendi-  
15      tures for covered part D drugs for full-benefit  
16      dual eligible individuals under paragraph (3) all  
17      payments collected by a State under agreements  
18      under section 1927 for outpatient prescription  
19      drugs purchased in 2003 (not just for such pay-  
20      ments that were collected by the State in  
21      2003).

22           “(B) Pharmacy cost savings measures im-  
23      plemented by the State during the period that  
24      begins with 2003 and ends with 2006.



1           “(C) Substituting under paragraph (4) a  
 2           State-specific growth factor in lieu of the na-  
 3           tional applicable growth factor for 2004 and  
 4           succeeding years based on the annual percent-  
 5           age increase in the State’s average per capita  
 6           aggregate expenditures for covered outpatient  
 7           drugs.

8           Such regulations shall include procedures for adjust-  
 9           ing payments to States under section 1903(a) to  
 10          take into account any overpayments or underpay-  
 11          ments which the Secretary determines on the basis  
 12          of such modifications were made by States under  
 13          this subsection for 2004 and succeeding years.”.

14 **SEC. 110. NO IMPACT ON ELIGIBILITY FOR BENEFITS**  
 15 **UNDER OTHER PROGRAMS.**

16          (a) IN GENERAL.—Section 1860D–14(a)(3) of the  
 17 Social Security Act (42 U.S.C. 1395w–114(a)(3)), is  
 18 amended—

19           (1) in subparagraph (A), in the matter pre-  
 20          ceding clause (i), by striking “subparagraph (F)”  
 21          and inserting “subparagraphs (F) and (H)”; and

22           (2) by adding at the end the following new sub-  
 23          paragraph:

24           “(H) NO IMPACT ON ELIGIBILITY FOR  
 25          BENEFITS UNDER OTHER PROGRAMS.—The

1           availability of premium and cost-sharing sub-  
 2           sidies under this section shall not be treated as  
 3           benefits or otherwise taken into account in de-  
 4           termining an individual’s eligibility for, or the  
 5           amount of benefits under, any other Federal  
 6           program.”.

7           (b) EFFECTIVE DATE.—The amendments made by  
 8 this section shall take effect on the date of enactment of  
 9 this Act.

10 **SEC. 111. QUALITY INDICATORS FOR DUAL ELIGIBLE INDI-**  
 11 **VIDUALS.**

12           Section 1154(a) of the Social Security Act (42 U.S.C.  
 13 1320c–3(a)) is amended by inserting after paragraph (11)  
 14 the following new paragraph:

15           “(12) For all contracts entered into on or after  
 16 August 1, 2011, the organization shall produce a  
 17 statistically valid subsample of quality indicators ap-  
 18 plicable to dual eligible beneficiaries under titles  
 19 XVIII and XIX.”.

1 **TITLE II—ADDITIONAL MEDI-**  
 2 **CARE AND MEDICAID IM-**  
 3 **PROVEMENTS**

4 **Subtitle A—Improving the Finan-**  
 5 **cial Assistance Available to**  
 6 **Low-Income Medicare Bene-**  
 7 **ficiaries**

8 **SEC. 201. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**  
 9 **INGS PROGRAM AND LOW-INCOME SUBSIDY**  
 10 **PROGRAM.**

11 (a) APPLICATION OF HIGHEST LEVEL PERMITTED  
 12 UNDER LIS.—

13 (1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIV-  
 14 IDUALS.—Section 1860D–14(a) of the Social Secu-  
 15 rity Act (42 U.S.C. 1395w–114(a)) is amended—

16 (A) in paragraph (1), in the matter before  
 17 subparagraph (A), by inserting “(or, beginning  
 18 with 2010, paragraph (3)(E))” after “para-  
 19 graph (3)(D)”;

20 (B) in paragraph (3)(A)(iii), by striking  
 21 “(D) or”.

22 (2) ANNUAL INCREASE IN LIS RESOURCE  
 23 TEST.—Section 1860D–14(a)(3)(E)(i) of the Social  
 24 Security Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is  
 25 amended—

1 (A) by striking “and” at the end of sub-  
 2 clause (I);

3 (B) in subclause (II), by inserting “(before  
 4 2010)” after “subsequent year”;

5 (C) by striking the period at the end of  
 6 subclause (II) and inserting a semicolon;

7 (D) by inserting after subclause (II) the  
 8 following new subclauses:

9 “(III) for 2010, \$27,500 (or  
 10 \$55,000 in the case of the combined  
 11 value of the individual’s assets or re-  
 12 sources and the assets or resources of  
 13 the individual’s spouse); and

14 “(IV) for a subsequent year, the  
 15 dollar amounts specified in this sub-  
 16 clause (or subclause (III)) for the pre-  
 17 vious year increased by the annual  
 18 percentage increase in the consumer  
 19 price index (all items; U.S. city aver-  
 20 age) as of September of such previous  
 21 year.”; and

22 (E) in the last sentence, by inserting “or  
 23 (IV)” after “subclause (II)”.

24 (3) APPLICATION OF LIS TEST UNDER MEDI-  
 25 CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of

1 the Social Security Act (42 U.S.C. 1396d(p)(1)(C))  
 2 is amended by striking “subparagraph (D)” and all  
 3 that follows through the period at the end and in-  
 4 serting the following: “section 1860D–14(a)(3)(E)  
 5 applicable to an individual or to the individual and  
 6 the individual’s spouse (as the case may be)”.

7 (b) EFFECTIVE DATE.—The amendments made by  
 8 subsection (a) shall apply to eligibility determinations for  
 9 income-related subsidies and Medicare cost-sharing fur-  
 10 nished for periods beginning on or after January 1, 2010.

11 **SEC. 202. ELIMINATING BARRIERS TO ENROLLMENT.**

12 (a) ENCOURAGING APPLICATION OF PROCEDURES  
 13 UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)  
 14 of the Social Security Act (42 U.S.C. 1396d(p)) is amend-  
 15 ed by adding at the end the following new paragraph:

16 “(7) The Secretary shall take all reasonable steps to  
 17 encourage States to provide for administrative verification  
 18 of income and automatic reenrollment (as provided under  
 19 subparagraphs (C)(iii) and (G) of section 1860D–14(a)(3)  
 20 in the case of the low-income subsidy program).”.

21 (b) ENSURING THAT SSA AND STATES CAN ELEC-  
 22 TRONICALLY PROCESS ALL LOW-INCOME SUBSIDY PRO-  
 23 GRAM APPLICATIONS.—Section 1860D–14(a)(3)(B)(i) of  
 24 the Social Security Act (42 U.S.C. 1395w–  
 25 114(a)(3)(B)(i)) is amended by inserting after the first

1 sentence the following new sentence: “Not later than Jan-  
 2 uary 1, 2012, the State plan and the Commissioner shall  
 3 have in place procedures to ensure the capacity to process  
 4 all applications for determinations (including all applica-  
 5 tions that are not in English) electronically.”.

6 **SEC. 203. ELIMINATION OF PART D COST-SHARING FOR**  
 7 **CERTAIN NON-INSTITUTIONALIZED FULL-**  
 8 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

9 (a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of  
 10 the Social Security Act (42 U.S.C. 1395w–  
 11 114(a)(1)(D)(i)) is amended—

12 (1) in the heading, by striking “INSTITU-  
 13 TIONALIZED INDIVIDUALS.—In” and inserting  
 14 “ELIMINATION OF COST-SHARING FOR CERTAIN  
 15 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

16 “(I) INSTITUTIONALIZED INDIVIDUALS.—In”; and  
 17

18 (2) by adding at the end the following new sub-  
 19 clauses:

20 “(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual  
 21 who is a full-benefit dual eligible indi-  
 22 vidual and who is being provided med-  
 23 ical assistance for home and commu-  
 24 nity-based services under subsection  
 25

1 (c), (d), (e), (i), or (j) of section 1915  
 2 or pursuant to section 1115, the  
 3 elimination of any beneficiary coinsur-  
 4 ance described in section 1860D–  
 5 2(b)(2) (for all amounts through the  
 6 total amount of expenditures at which  
 7 benefits are available under section  
 8 1860D–2(b)(4)).”.

9 (b) EFFECTIVE DATE.—The amendments made by  
 10 subsection (a) shall apply to drugs dispensed on or after  
 11 January 1, 2010.

12 **SEC. 204. EXEMPTION OF BALANCE IN ANY PENSION OR RE-**  
 13 **TIREMENT PLAN FROM RESOURCES FOR DE-**  
 14 **TERMINATION OF ELIGIBILITY FOR LOW-IN-**  
 15 **COME SUBSIDY.**

16 (a) IN GENERAL.—Section 1860D–14(a)(3) of the  
 17 Social Security Act (42 U.S.C. 1395w–114(a)(3)) is  
 18 amended—

19 (1) in subparagraph (D), in the matter before  
 20 clause (i), by striking “life insurance policy exclusion  
 21 provided under subparagraph (G)” and inserting  
 22 “additional exclusions provided under subparagraphs  
 23 (G) and (H)”;

24 (2) in subparagraph (E)(i), in the matter before  
 25 subclause (I), by striking “life insurance policy ex-

1 exclusion provided under subparagraph (G)” and in-  
 2 serting “additional exclusions provided under sub-  
 3 paragraphs (G) and (H)”;

4 (3) by adding at the end the following new sub-  
 5 paragraph:

6 “(H) PENSION OR RETIREMENT PLAN EX-  
 7 CLUSION.—In determining the resources of an  
 8 individual (and the eligible spouse of the indi-  
 9 vidual, if any) under section 1613 for purposes  
 10 of subparagraphs (D) and (E), no balance in  
 11 any pension or retirement plan shall be taken  
 12 into account.”.

13 (b) EFFECTIVE DATE.—The amendments made by  
 14 this section shall take effect on January 1, 2010, and shall  
 15 apply to determinations of eligibility for months beginning  
 16 with January 2010.

17 **SEC. 205. COST-SHARING PROTECTIONS FOR LOW-INCOME**  
 18 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

19 (a) IN GENERAL.—Section 1860D–14(a) of the So-  
 20 cial Security Act (42 U.S.C. 1395w–114(a)) is amended—

21 (1) in paragraph (1)(D), by adding at the end  
 22 the following new clause:

23 “(iv) OVERALL LIMITATION ON COST-  
 24 SHARING.—In the case of all such individ-  
 25 uals, a limitation on aggregate cost-sharing



1 under this part for a year not to exceed  
 2 2.5 percent of income.”; and

3 (2) in paragraph (2), by adding at the end the  
 4 following new subparagraph:

5 “(F) OVERALL LIMITATION ON COST-SHAR-  
 6 ING.—A limitation on aggregate cost-sharing  
 7 under this part for a year not to exceed 2.5 per-  
 8 cent of income.”.

9 (b) EFFECTIVE DATE.—The amendments made by  
 10 subsection (a) shall apply as of January 1, 2010.

## 11 **Subtitle B—Other Improvements**

### 12 **SEC. 211. ENROLLMENT IMPROVEMENTS UNDER MEDI-** 13 **CARE PARTS C AND D.**

14 (a) SPECIAL ELECTION PERIOD DURING FIRST 60  
 15 DAYS OF ENROLLMENT IN A NEW PLAN.—

16 (1) IN GENERAL.—Section 1851(e)(4) of the  
 17 Social Security Act (42 U.S.C. 1395w(e)(4)) is  
 18 amended—

19 (A) in subparagraph (C), by striking “or”  
 20 at the end;

21 (B) by redesignating subparagraph (D) as  
 22 subparagraph (E); and

23 (C) by inserting after subparagraph (C)  
 24 the following new subparagraph:

1           “(D) the individual has been enrolled in  
2           such plan for fewer than 60 days; or”.

3           (2) EFFECTIVE DATE.—The amendments made  
4           by paragraph (1) shall take effect on the date that  
5           is 90 days after the date of enactment of this Act.

6           (b) EXTENSION OF THE ANNUAL, COORDINATED  
7 ELECTION PERIOD.—

8           (1) IN GENERAL.—Section 1851(e)(3)(B)(iv) of  
9           the Social Security Act (42 U.S.C. 1395w–  
10          1(e)(3)(B)(iv)) is amended by striking “November  
11          15” and inserting “October 1”.

12          (2) EFFECTIVE DATE.—The amendment made  
13          by paragraph (1) shall apply to annual, coordinated  
14          election periods beginning after the date of enact-  
15          ment of this Act.

16          (c) COORDINATION UNDER PARTS C AND D OF THE  
17 CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT  
18 PERIOD FOR THE FIRST 3 MONTHS OF THE YEAR.—

19          (1) IN GENERAL.—Section 1860D–  
20          1(b)(1)(B)(iii) of the Social Security Act (42 U.S.C.  
21          1395w–101(b)(1)(B)(iii)) is amended by striking “,  
22          (C),”.

23          (2) EFFECTIVE DATE.—The amendment made  
24          by paragraph (1) shall take effect on January 1,  
25          2010.

1 **SEC. 212. MEDICARE PLAN COMPLAINT SYSTEM.**

2 (a) SYSTEM.—Section 1808 of the Social Security  
3 Act (42 U.S.C. 1395b–9) is amended—

4 (1) in subsection (c)(2)—

5 (A) in subparagraph (B)(iii), by striking  
6 “adjustment; and” and inserting “adjust-  
7 ment);”;

8 (B) in subparagraph (C), by striking the  
9 period at the end and inserting “; and”; and

10 (C) by adding at the end the following new  
11 subparagraph:

12 “(D) develop and maintain the plan com-  
13 plaint system under subsection (d).”; and

14 (2) by adding at the end the following new sub-  
15 section:

16 “(d) PLAN COMPLAINT SYSTEM.—

17 “(1) SYSTEM.—

18 “(A) IN GENERAL.—The Secretary shall  
19 develop and maintain a plan complaint system,  
20 (in this subsection referred to as the ‘system’)  
21 to—

22 “(i) collect and maintain information  
23 on plan complaints;

24 “(ii) track plan complaints from the  
25 date the complaint is logged into the sys-

tem through the date the complaint is resolved; and

“(iii) otherwise improve the process for reporting plan complaints.

“(B) TIMEFRAME.—The Secretary shall have the system in place by not later than the date that is 6 months after the date of enactment of this subsection.

“(C) PLAN COMPLAINT DEFINED.—In this subsection, the term ‘plan complaint’ means a complaint that is received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor) from a Medicare Advantage eligible individual or a part D eligible individual (or an individual representing such an individual) regarding a Medicare Advantage organization, a Medicare Advantage plan, a prescription drug plan sponsor, or a prescription drug plan, including, but not limited to, complaints relating to marketing, enrollment, covered drugs, premiums and cost-sharing, and plan customer service, grievances

1 and appeals, participating providers. Such term  
2 also includes plan complaints that are received  
3 by the Secretary directly from the organization  
4 offering the plan relating to complaints by such  
5 individuals.

6 “(2) PROCESS CRITERIA.—In developing the  
7 system, the Secretary shall establish a process for  
8 reporting plan complaints. Such process shall meet  
9 the following criteria:

10 “(A) ACCESSIBLE.—The process is widely  
11 known and easy to use.

12 “(B) INVESTIGATIVE CAPACITY.—The  
13 process involves the appropriate experts, re-  
14 sources, and methods to assess complaints and  
15 determine whether they reflect an underlying  
16 pattern.

17 “(C) INTERVENTION AND FOLLOW-  
18 THROUGH.—The process triggers appropriate  
19 interventions and monitoring based on substan-  
20 tiated complaints.

21 “(D) QUALITY IMPROVEMENT ORIENTA-  
22 TION.—The process guides quality improve-  
23 ment.

1           “(E) RESPONSIVENESS.—The process rou-  
 2           tinely provides consistent, clear, and substantive  
 3           responses to complaints.

4           “(F) TIMELINES.—Each process step is  
 5           completed within a reasonable, established time-  
 6           frame, and mechanisms exist to deal quickly  
 7           with complaints of an emergency nature requir-  
 8           ing immediate attention.

9           “(G) OBJECTIVE.—The process is unbi-  
 10          ased, balancing the rights of each party.

11          “(H) PUBLIC ACCOUNTABILITY.—The  
 12          process makes complaint information available  
 13          to the public.

14          “(3) STANDARD DATA REPORTING REQUIRE-  
 15          MENTS.—

16               “(A) IN GENERAL.—The Secretary shall  
 17               establish standard data reporting requirements  
 18               for reporting plan complaints under the system.

19               “(B) MODEL ELECTRONIC COMPLAINT  
 20               FORM.—The Secretary shall develop a model  
 21               electronic complaint form to be used for report-  
 22               ing plan complaints under the system. Such  
 23               form shall be prominently displayed on the  
 24               front page of the Medicare.gov Internet website

1           and on the Internet website of the Medicare  
2           Beneficiary Ombudsman.

3           “(4) ALL COMPLAINTS REQUIRED TO BE  
4           LOGGED INTO THE SYSTEM.—Every plan complaint  
5           shall be logged into the system.

6           “(5) CASEWORK NOTATIONS.—The system shall  
7           provide for the inclusion of any casework notations  
8           throughout the complaint process on the record of a  
9           plan complaint.

10          “(6) MEDICARE BENEFICIARY OMBUDSMAN.—  
11          The Secretary shall carry out this subsection acting  
12          through the Medicare Beneficiary Ombudsman.”.

13          (b) FUNDING.—There are authorized to be appro-  
14          priated such sums as may be necessary for the costs of  
15          carrying out section 1808(d) of the Social Security Act,  
16          as added by subsection (a).

17          (c) REPORTS.—

18                  (1) SECRETARY.—

19                          (A) ONGOING STUDY.—The Medicare Ben-  
20                          eficiary Ombudsman (under subsection (c) of  
21                          section 1808) of the Social Security Act (42  
22                          U.S.C. 1395b–9) shall conduct an ongoing  
23                          study of the plan complaint system established  
24                          under subsection (d) of such section (as added  
25                          by subsection (a)), in this subsection referred to

1 as the “system”. Such study shall include an  
2 analysis of—

3 (i) the numbers and types of com-  
4 plaints reported under the system;

5 (ii) geographic variations in such com-  
6 plaints;

7 (iii) the timeliness of agency or plan  
8 responses to such complaints; and

9 (iv) the resolution of such complaints.

10 (B) QUARTERLY REPORTS.—Not later  
11 than 6 months after the implementation of the  
12 system, and every 3 months thereafter, the Sec-  
13 retary of Health and Human Services shall sub-  
14 mit to Congress a report on the study con-  
15 ducted under subparagraph (A), together with  
16 recommendations for such legislation and ad-  
17 ministrative actions as the Secretary determines  
18 appropriate.

19 (2) INSPECTOR GENERAL.—The Inspector Gen-  
20 eral of the Department of Health and Human Serv-  
21 ices shall conduct an evaluation of the system. Not  
22 later than 1 year after the implementation of the  
23 system, the Inspector General shall submit to Con-  
24 gress a report on such evaluation, together with rec-  
25 ommendations for such legislation and administra-



1       tive actions as the Inspector General determines ap-  
 2       propriate.

3   **SEC. 213. UNIFORM EXCEPTIONS AND APPEALS PROCESS.**

4       (a) IN GENERAL.—Section 1860D–4(b)(3) of the So-  
 5   cial Security Act (42 U.S.C. 1395w–104(b)(3)), as amend-  
 6   ed by section 107, is amended by adding at the end the  
 7   following new subparagraph:

8               “(G) USE OF SINGLE, UNIFORM EXCEP-  
 9               TIONS AND APPEALS PROCESS.—Notwith-  
 10              standing any other provision of this part, a  
 11              PDP sponsor of a prescription drug plan or an  
 12              MA organization offering an MA–PD plan  
 13              shall—

14               “(i) use a single, uniform exceptions  
 15               and appeals process with respect to the de-  
 16               termination of prescription drug coverage  
 17               for an enrollee under the plan; and

18               “(ii) provide instant access to such  
 19               process by enrollees through a toll-free  
 20               telephone number and an Internet  
 21               website.”.

22       (b) EFFECTIVE DATE.—The amendments made by  
 23   subsection (a) shall apply to exceptions and appeals on  
 24   or after January 1, 2011.

1 **SEC. 214. PROHIBITION ON CONDITIONING MEDICAID ELI-**  
 2 **GIBILITY FOR INDIVIDUALS ENROLLED IN**  
 3 **CERTAIN CREDITABLE PRESCRIPTION DRUG**  
 4 **COVERAGE ON ENROLLMENT IN THE MEDI-**  
 5 **CARE PART D DRUG PROGRAM.**

6 (a) IN GENERAL.—Section 1935 of the Social Secu-  
 7 rity Act (42 U.S.C. 1396v) is amended by adding at the  
 8 end the following:

9 “(f) PROHIBITION ON CONDITIONING ELIGIBILITY  
 10 FOR MEDICAL ASSISTANCE FOR INDIVIDUALS ENROLLED  
 11 IN CERTAIN CREDITABLE PRESCRIPTION DRUG COV-  
 12 ERAGE ON ENROLLMENT IN MEDICARE PRESCRIPTION  
 13 DRUG BENEFIT.—

14 “(1) IN GENERAL.—A State shall not condition  
 15 eligibility for medical assistance under the State  
 16 plan for a part D eligible individual (as defined in  
 17 section 1860D–1(a)(3)(A)) who is enrolled in cred-  
 18 itable prescription drug coverage described in any of  
 19 subparagraphs (C) through (H) of section 1860D–  
 20 13(b)(4) on the individual’s enrollment in a prescrip-  
 21 tion drug plan under part D of title XVIII or an  
 22 MA–PD plan under part C of such title.

23 “(2) COORDINATION OF BENEFITS WITH PART  
 24 D FOR OTHER INDIVIDUALS.—Nothing in this sub-  
 25 section shall be construed as prohibiting a State  
 26 from coordinating medical assistance under the

1 State plan with benefits under part D of title XVIII  
 2 for individuals not described in paragraph (1).”.

3 **SEC. 215. OFFICE OF THE INSPECTOR GENERAL ANNUAL**  
 4 **REPORT ON PART D FORMULARIES’ INCLU-**  
 5 **SION OF DRUGS COMMONLY USED BY DUAL**  
 6 **ELIGIBLES.**

7 (a) ONGOING STUDY.—The Inspector General of the  
 8 Department of Health and Human Services shall conduct  
 9 an ongoing study of the extent to which formularies used  
 10 by prescription drug plans and MA–PD plans under part  
 11 D include drugs commonly used by full-benefit dual eligi-  
 12 ble individuals (as defined in section 1935(c)(6) of the So-  
 13 cial Security Act (42 U.S.C. 1396u–5(c)(6))).

14 (b) ANNUAL REPORTS.—Not later than July 1 of  
 15 each year (beginning with 2010), the Inspector General  
 16 shall submit to Congress a report on the study conducted  
 17 under paragraph (1), together with such recommendations  
 18 as the Inspector General determines appropriate.

19 **SEC. 216. HHS ONGOING STUDY AND ANNUAL REPORTS ON**  
 20 **COVERAGE FOR DUAL ELIGIBLES.**

21 (a) ONGOING STUDY.—

22 (1) IN GENERAL.—The Secretary of Health and  
 23 Human Services (in this section referred to as the  
 24 “Secretary”) shall conduct an ongoing study to  
 25 track—

1 (A) how many of the new full benefit dual  
 2 eligible individuals (as defined in section  
 3 1935(c)(6) of the Social Security Act (42  
 4 U.S.C. 1395u–5(c)(6))) enroll in a plan under  
 5 part D of title XVIII of such Act and receive  
 6 retroactive prescription drug coverage under the  
 7 plan; and

8 (B) if such retroactive coverage is provided  
 9 to such individuals—

10 (i) the number of months of coverage  
 11 provided; and

12 (ii) the amount of reimbursements to  
 13 individuals and to individuals that made  
 14 payments for prescription drugs on their  
 15 behalf for costs incurred during retroactive  
 16 coverage periods.

17 (2) DATA TO USE.—In conducting the study  
 18 with respect to the requirements under paragraph  
 19 (1)(B), the Secretary shall examine prescription  
 20 drug utilization data reported by Medicare part D  
 21 plans.

22 (b) ANNUAL REPORTS ON ONGOING STUDY.—Not  
 23 later than March 1 of each year (beginning with 2010),  
 24 the Secretary shall submit a report to Congress containing  
 25 the results of the study conducted under subsection (a),

1 together with recommendations for such legislation and  
2 administrative action as the Secretary determines appro-  
3 priate.

4 (c) ANNUAL REPORTS ON SPENDING AND OUT-  
5 COMES.—Not later than January 1 of each year (begin-  
6 ning with 2013), the Secretary shall collect data and sub-  
7 mit a report to Congress that includes the following infor-  
8 mation:

9 (1) Annual total expenditures (disaggregated by  
10 Federal and State expenditures) for dually eligible  
11 beneficiaries under title XVIII and under State  
12 plans and waivers under title XIX.

13 (2) An analysis of health outcomes for dually  
14 eligible beneficiaries, disaggregated by subtypes of  
15 beneficiaries (as determined by the Secretary).

16 (3) An analysis of the extent to which dually el-  
17 igible beneficiaries are able to access benefits under  
18 title XVIII and under State plans and waivers under  
19 title XIX.

20 **SEC. 217. AUTHORITY TO OBTAIN INFORMATION.**

21 Title XVIII of the Social Security Act (42 U.S.C.  
22 1395 et seq.) is amended by adding at the end the fol-  
23 lowing new section:

1           “AUTHORITY OF THE COMPTROLLER GENERAL TO  
2                           OBTAIN INFORMATION

3           “SEC. 1899. No provision in this Act in effect on the  
4 date of enactment of this section or enacted after such  
5 date shall be construed to limit, amend, or supersede the  
6 authority of the Comptroller General of the United States  
7 to obtain agency records pursuant to section 716 of title  
8 31, United States Code, including any information ob-  
9 tained by, or disclosed to, the Secretary under part C or  
10 D of this title, except to the extent that such provision  
11 expressly and specifically refers to this section and pro-  
12 vides for such limitation, amendment, or supersession.”.

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